TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON MEDICAL GROUP

Respondent Name
CHARTER OAK FIRE INSURANCE CO

MFDR Tracking Number
M4-17-0426-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
October 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Initially the claim was submitted on 11/19/2015 and 11/26/2015. We received the Denial for the above claim with a denial of Travelers needing medical documentation. I can assure you that everything was submitted properly. Till this day we have yet to receive any payments on the above DOS. Enclosed I have submitted all information according to timely filing so that, that's not the issue."

Amount in Dispute: $400.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "THIS REQUEST FOR MEDICAL FEE DISPUTE RESOLUTION SHOULD BE DISMISSED IN ACCORDANCE WITH RULE 133.307(f)(3)(D) AS THE PROVIDER FAILED TO TIMELY FILE THEIR REQUEST WITHIN ONE YEAR OF THE DATES OF SERVICE AS REQUIRED BY RULE 133.307(C)(1)(A) ."

Response Submitted by: TRAVELERS, PO BOX 163201 AUSTIN, TX 78716

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 08, 2015	CPT Codes 97150-GP-59, 97140-GP, G0283-GP and 97010-GP-59	$189.91	$0.00
October 16, 2015	CPT Codes 97110-GP-59 and 97140-GP	$210.22	

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 167 – The billed diagnosis code(s) is/are not related to this Workers' Compensation claim
   - P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - 86 – Service performed was distinct or independent from other services performed on the same day
   - 247 – A payment or denial has already been recommended for this service
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - 16 – Claim/service lacks information which is needed for adjudication, additional information is supplied using remittance advice remarks codes whenever appropriate
   - DOCM – Document medical

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is October 08, 2015 and October 16, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 18, 2016. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/17/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.